

**VERIFICATION OF LIABILITY COVERAGE
FOR DIVING UNDER NOAA AUSPICES**

Name of Contract Diver: _____

Name of Company/Employer: _____

Name of NOAA Line Office/Unit assigned: _____

This is to verify that the above named individual is covered for costs associated with any dive accident or other medical emergency that may occur during the course of his/her work at or with NOAA.

Note: Please indicate below the type and extent of coverage, including, but not limited to: emergency transportation (e.g., MEDIVAC), hyperbaric or other medical treatment, hospitalization, and compensation for lost wages associated with extended absence due to work-related medical emergencies (e.g., workers' compensation). You may attach additional information, if necessary.

<u>Type & Extent of Coverage</u>	<u>Dates of Coverage</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Comments:

Signature of Company Representative

Title/Position

Date